

7. ABSTRACT

A system and method for processing patient data permits physicians and other medical staff personnel to record, accurately and precisely, historical patient care information. An objective measure of a physician's rendered level of care, as described by a clinical status code, is automatically generated. Data elements used in the determination of the generated clinical status code include a level of history of the patient, a level of examination of the patient, a decision-making process of the physician treating the patient, and a "time influence factor." The quantity and quality of care information for a particular patient is enhanced allowing future care decisions for that patient to be based on a more complete medical history. Enhanced care information can be used in outcome studies to track the efficacy of specific treatment protocols. Archiving of patient information is done in a manner which allows reconstruction of the qualitative aspects of provided medical services. The medical care data can be recorded, saved, and transferred from a portable system to a larger stationary information or database system. Considerable physician and staff time are saved and precision and accuracy are significantly enhanced, by generating these clinical status codes automatically (at the point of service by the care-provider without any intermediary steps) from information recorded simultaneously with the provision of services.